

Society Proceedings.

NEW YORK NEUROLOGICAL SOCIETY.

Meeting of October 4th, 1887.

The President, DR. C. L. DANA, in the Chair.

THE ARTHROPATHY OF TABES.

DR. W. H. PORTER presented a specimen of the spinal cord and the knee joint from a case of tabes. The patient was a woman, 32 years old. The family history was good. There was no history of alcoholism or rheumatism in the case. In May of the present year, ovariotomy had been done, and, with the exception of the formation of a ventral hernia, the patient had made a good recovery. The affection of the spinal cord dated from five months previously, and in February last a gradual increase in the size of the knee had been noted. As early as December 15th, however, the patient had suffered pain, and partial luxation had made standing difficult. Examination showed the right knee painful, but not swollen. The left knee presented subluxation, some fluid, and enlargement of the lower portion of the femur. There was some dyspnoea, also some headache. The patient also suffered with external haemorrhoids, but the urine was normal, and the co-ordination good. The right knee measured 18 inches, and the left 21 $\frac{1}{2}$. The patient was a large woman, weighing 300 pounds. The enlargement and the riding of the patella upon the joint were all the positive symptoms in the case, and the patient was transferred to the surgical ward. There continued to be a great deal of boring pain in the knee, but no puffy feeling in the feet, no anaesthesia, and no ocular trouble. The joint was excised with an apparently good result, but three weeks later, on August 10th, discolouration of the skin of the buttocks and of the small of the back appeared, and in the course of a day or two the part sloughed. The woman died, apparently of sepsis from the slough. Post mortem the viscera were found healthy with the exception

of the liver, which was pock-marked with cicatricial depressions. The right knee joint was found in good condition. Moderate changes of interstitial thickening were found in the spinal cord. The question was, whether this should be considered a case of ataxia, the only positive symptom being the boring pain. The supposition of tuberculosis had been entertained, but the excised joint had failed to show tubercular tissue or bacilli, and erosion of the bones had been the only discoverable change.

The PRESIDENT added that the spinal cord was now being examined by Dr. Græme M. Hammond, and there was no doubt that the posterior columns, particularly the postero-external columns, or columns of Burdach, were affected. It was a case of sclerosis of the cord, most marked in the posterior columns.

DR. W. A. HAMMOND suggested that articular affections with locomotor ataxia were infrequent in this country as compared with France. He had never seen a case, although many cases of locomotor ataxia had passed under his notice. According to Charcot, they were very common, resembling in this the *grande hystérie*, which also seemed limited to France, and even to the walls of the Salpêtrière Hospital.

DR. PORTER stated that during the past year he had made post-mortem examinations in four cases of locomotor ataxia. In two of these there were joint affections, and in two there were none. They had been recognized during life in only one of the cases. He had never seen the condition before this year.

DR. L. WEBER referred to a case which had been presented the day before at the Society of German Physicians. He had seen others, but not such as would answer to Charcot's descriptions. Rosenthal, of Vienna, also had described severe joint affections in locomotor ataxia, but not in such great numbers. The speaker could point to a few cases out of 70 or 75, but as a rule the affection had not been destructive. It was acute; it would come and go, and complete restitution might occur. He referred to two cases. In one there were diabetes and locomotor ataxia, and in the other there was sclerosis of the cervical region of the cord. In this case it looked as if the cartilage and bone were invaded, as there were crackling and change in form. A case like that referred to as presented the day before, with intra-capsular fracture and such extreme mobility, he had never seen before in this country.

The PRESIDENT, from an experience embracing two cases, had

found that the term tabetic arthropathy did not mean the same thing under all conditions. One of the patients, whose case was of ten years' standing, slipped and fell, nearly dislocating a joint already loose, so as to present a typical arthropathy of this disease.

MELANCHOLIA DUE TO THE PROLONGED USE OF MORPHINE.

DR. S. B. LYON presented the history of a case of melancholia following the prolonged use of morphine for the relief of cardiac pain.¹

DR. M. PUTNAM JACOBI considered the case very interesting. The conception of the ego as a simple unit was childish. Undoubtedly changes might occur in the groupings which went to form the consciousness of which the ego was made up. In this case there was destruction of the ordinary linkings of consciousness, with a replacement of the ordinary normal impressions by the formation of a new sphere. The aberrations produced by morphine and other toxic influences could be explained in like manner. The suddenness of the recovery in this case further demonstrated that the forced paths of association had ceased to be travelled and the old ones been resumed—a process which might be likened to the switching of an engine from one track to another.

DR. HAMMOND objected to the term double consciousness in connection with the case. Double consciousness might be represented by plus and minus. The patient was not at the same moment in both conditions, but at different periods led separate lives, during the plus condition knowing nothing of what occurred during the minus condition, and *vice versa*.

DR. E. C. SPITZKA thought that the reader of the paper had used the term with the meaning of the French. The case was assuredly not one of double consciousness as the term was used by alienists. In double consciousness there was really a double ego with alternate consciousness.

DR. LYON recognized that the case was not one of double consciousness as Dr. Hammond and Dr. Spitzka had used the term. The patient had, however, a double consciousness in an ordinary acceptation of the word, with a real and an unreal aspect, the latter dominating.

¹ See this number.

A DISCUSSION ON THE USE OF ANTIPYRINE AND ANTI FEBRINE IN NERVOUS DISEASES.

was opened by DR. T. S. ROBERTSON. He had used antipyrine first, in general practice, in acute rheumatism, and it had appeared not only to reduce the fever, but to control the pain. This had led him to try it in a case of migraine which had resisted aconitine and chloral. He had subsequently given it in a hundred unselected cases. In 90 per cent of these, relief had been obtained in from fifteen to forty-five minutes. He had given it without a stimulant, and diaphoresis was the only ill effect which he had seen. In the severe pains of tabes he had given from ten to twenty grains hypodermically, or from twenty to thirty by the mouth, with a resulting diminution in frequency. In insomnia, the sleep was better than that produced by chloral. The speaker had never seen heart failure. In hyperpyrexia he gave forty grains at a dose, and had himself taken one hundred and twenty grains in the course of twenty-four hours without any unpleasant result.

DR. E. WAITZFELDER had had an experience somewhat similar to Dr. Robertson's, but had given the drug with a stimulant, having found nausea and vomiting common where this was not used. He had given antipyrine in twenty miscellaneous cases of headache, producing relief in about fifty per cent. He had directed its use in the epileptic ward about three months ago. It had been thoroughly tried, but without any appreciable effect. He had used it for the pains of locomotor ataxia, but, while the patients had improved, he did not attribute this to the drug.

DR. HAMMOND had used antipyrine, and his experience had been entirely negative. He had given both antipyrine and anti febrine, singly and combined, in neuralgia, the pain of locomotor ataxia, insomnia, vertigo, and headaches both of the anæmic and of the hyperæmic variety. His method of administration had been to give fifteen-grain doses three times a day, continued for from two to three weeks. A new drug was not needed to shorten an attack of migraine. A hypodermic injection of morphine would do it, or one hundred grains of bromide of sodium, or $\frac{1}{100}$ of a grain of nitro-glycerin, according to the variety. In a case of tuberculous meningitis in a child of two years, he had given four-grain doses of antipyrine for the relief of pain, and had signally failed. He had given it in epilepsy without result.

The PRESIDENT asked whether Dr. Hammond had given antifebrine in epilepsy.

DR. HAMMOND had given both antipyrine and antifebrine in fifteen-grain doses, with similar results, sometimes combining seven grains and a half of each. He referred to the insolubility of antipyrine, making its administration difficult.

DR. G. W. JACOBY thought it serviceable to hear the other side of this question. His own experience had resembled that of Dr. Hammond. Antipyrine gave some relief in migraine, at least following the first or second administration. It sometimes cut short insomnia, but that about comprised its usefulness in this field. It was not without danger. He had seen collapse from a dose of twenty grains.

DR. M. PUTNAM JACOBI had given antifebrine in the infirmary to a child with pleuro-pneumonia, and, with lowering of the temperature, relief from pain also was produced, although the physical signs remained unaltered and defervescence occurred in a typical manner on the sixth day.

DR. SACHS believed that antipyrine could be recommended only in migraine, possibly also in headache of a neurasthenic type. Cases should be followed up for a number of months. The results from two or three administrations should not be relied upon. He had given it in a dozen cases of migraine, with relief within twenty minutes after its first administration, and in no case had it been necessary to repeat the dose more than two or three times, at intervals of an hour. The only unsatisfactory cases had been those of the spastic type.. The paralytic type had been in every case relieved. In one case, that of a man of thirty-two years, the condition had resisted all previous treatment. The patient every four weeks had to go to bed for from twelve to thirty-six hours, and was incapacitated for work for several days. Antipyrine did not entirely relieve the headache in this case, but the patient was able to continue his business during the paroxysm. In the speaker's experience, about 20 per cent of the headaches of neurasthenic origin were relieved. In headaches of anaemic and gastric origin, the treatment had been unsatisfactory. In insomnia, with and without migraine, antipyrine had appeared to act as a true narcotic. Sleep of nine hours and a half to ten hours followed the administration of two grains. He had used it in the lightning pains of locomotor ataxia and in peripheral neuralgias, particularly trigeminal and sciatic, without result

Antipyrine was not a panacea; and the speaker thought that it should be used carefully. He had met with no bad results himself, but from the reports of others it was evident that such results could occur.

The PRESIDENT expressed surprise that Dr. Hammond had been so unsuccessful in the use of antipyrine, and suggested that he keep a closer watch upon his clinical assistants. Dr. C. H. Brown professed to have been cured of a most violent migraine by antipyrin, and was enthusiastically prescribing it in Dr. Hammond's clinic. In the treatment of epilepsy, antipyrine could only be used empirically. Antifebrine, on the contrary, had been shown to act as a spinal depressant, and hence could be rationally prescribed.

DR. ROBERTSON had found antipyrine soluble in Vichy water. He considered a dose of from twenty to thirty grains safe. He had not maintained that it cured, but that it acted as a palliative in the conditions named.

Meeting held Tuesday evening, November 1st, 1887.

The President, DR. C. L. DANA, in the Chair.

DR. BEVERLY ROBINSON presented a case of

APHASIA WITHOUT PARALYSIS.

The history had been furnished by the assistant house physician to Charity Hospital. The patient was 68 years of age, born in this country and admitted to Charity Hospital Aug. 25th of the present year. His previous history was negative in regard to syphilis. He once had had rheumatism in the knees, but the date was not known. His present difficulty dated from May, when he commenced to have headache. Subsequently he fell out of bed to the floor. He was able to crawl back into bed, but from this time his speech was affected. He was treated in Bellevue Hospital, and was from there transferred to Charity Hospital upon the date named. Upon entry he was apparently in perfect physical health excepting speech. Objectively there were no signs of paralysis. His walk was slow but good. Possibly the right leg dragged a little. The dynamometer registered twenty with the right hand and with the left hand ten. The faradic reactions were normal in the upper extremities. In the lower extremities they were somewhat quicker and stronger upon the left than upon

the right side. The sight in the right eye was as good as before the injury. The right eye was found more hypermetropic than the left, but the optic disks showed the physiological cupping in both eyes. The urine was negative. When admitted the patient could speak only in monosyllables, using most frequently the phrases "Yes," "No," "That's it," and "Exactly." He read the newspaper and apparently understood what he read. He also used gestures and explanatory words. When asked his age, as "Are you 40?" he would answer "No;" "32?" "No;" "48?" "No;" "68?" "Yes." If given a pencil and paper and told to write his age he would put down an 8 and in front of it a 6, adding "That's it." He could not write his name, writing John in the place of Isaac. It thus appeared to the speaker a case of amnesic and ataxic aphasia with agraphia, depending upon lesion of the foot of the left third frontal convolution. His own interest in it had been directed to the question whether lesion of this area would involve the intrinsic muscles of the larynx. On account of the difficulty of obtaining intelligent co-operation, however, a satisfactory examination could not be made. The treatment had consisted in the administration of 15 grains of pot. iodid. t. i. d.

DR. DANA asked whether the patient could copy and whether mirror writing was obtained with the left hand.

DR. ROBINSON did not think that the patient could copy, but would test the point.

DR. DANA suggested that his own name be not used, and the President's was substituted. The patient wrote Charles Dane. Dr. Jacoby added another phrase and found that the patient wrote *s* for *m* and *f* for *i*.

DR. STARR would rule out amnesia in the case. The terms amnesic and ataxic aphasia had respectively a sensory and motor significance. Here the patient apparently understood perfectly, and his difficulty was purely ataxic or motor.

DR. ROBINSON explained that a few weeks ago the patient had not understood well, and that even at the present time he would probably not understand all questions which might be put to him. Yet, during the last two or three weeks, he had very markedly improved.

DR. BALL asked how carefully the question of sensory ability had been tested. When told to do certain things, would he do them? Also, would he do the same when written directions were given him?

DR. ROBINSON replied that the patient had complied with oral directions ; that written directions had not been tried.

DR. DANA asked whether the patient was able to utter exclamatory language. In some cases where ordinary speech was lost through lesion of the left third frontal convolution, profane or ejaculatory language was still obtained through the corresponding centre upon the right side.

DR. ROBINSON stated that the patient did not present this peculiarity.

DR. PUTNAM JACOBI asked whether the test suggested by Dr. Ball could not then be made.

DR. BALL directed the patient to take hold of Dr. Robinson's left thumb. The man hesitated and apparently failed to understand, but complied when directed simply to "Take his thumb."

DR. STARR asked the patient whether he read the papers and understood them, and the man replied, "Yes, of course."

DR. BALL mentioned the case of Dr. Chas. Allen, aphasic for several years and now dead. This case had, during most of the time, read and apparently understood, yet it was probable that he obtained the sense from leading words, and that a large number of the words he did not understand at all. Probably the same was true of this case.

DR. ROBINSON asked whether there was any recognized difficulty in the use of the intrinsic muscles of the larynx for phonation associated with the aphasic condition.

DR. STARR had been interested in this subject through a paper by Dr. Delavan in regard to a cortical centre for the larynx. For a year he had sent to Dr. Delavan all cases of hemiplegia coming to him at the Polyclinic and the Demilt Dispensary. Fifteen or sixteen cases had been examined without the discovery of any affection on either side of the larynx. He believed that no such case was upon record. It was certainly contrary to the general experience of neurologists to find any difficulty of phonation connected with aphasia. In fact, Dr. Ross, in his last edition, had stated that in the lesion of aphasia the muscles of the larynx were not affected.

DR. ROBINSON had retained an impression that the literature showed such cases. He had had his attention directed to the subject in this way.

DR. STARR asked whether a patient could have this paralysis of the larynx without being hoarse.

DR. ROBINSON replied that he could. He had seen patients with partial paralysis of a vocal chord who were not hoarse.

DR. GRAY stated that a distinction should be made between hemiplegias from lesion of the internal capsule, and those from lesions of other parts, particularly the pons and the medulla. Of six or seven cases in which hemiplegia was due to hemorrhage, embolus, or thrombus in the internal capsule, he had had careful examinations made by competent laryngologists, and in none of them was there any paralysis of the laryngeal muscles. In hemiplegia from other causes, alteration of the tone of voice was sometimes obtained. In true and simple aphasia he thought that the voice was not affected. Dr. Dana added that in pseudobulbar paralysis the larynx was involved, the lesion being in the corpus striatum.

DR. H. C. COE followed with a paper upon

THE SIGNIFICANCE OF PELVIC PAIN.

Pain was not a reliable indication of disease. Often an epithelioma of the cervix would cause less distress than a dislocation. The description of pain by the patient and the localization of its cause by the physician represented separate topics for thought. As described by the patient the pains of the pelvic regions were, in general terms, an aching pain in the lower part of the sacrum, a shooting pain in the inguinal regions, and the gnawing pain of carcinoma. All of these pains would be referred to some lesion of the peritoneal or connective tissue, or both—to some plastic exudation not necessarily of great amount. The distress caused by a retroflexed uterus was much greater where there were adhesions than when there were not. It was fair to assume that this constant aching pain was due to the implication of nerves in the exudate. Laceration of the cervix, excepting that extending into the vaginal fornix, did not, in itself, cause pain. The cervix was a very insensitive organ, and laceration was but a link in the chain of circumstances which resulted in pain. Malignant disease even did not necessarily give rise to pain. Hart and Barbour say that there is no pain so long as the cervix is affected, Hewitt says that the pain of cancer is due to localized attacks of peritonitis. The pain was earliest and most severe when the growth was in the body, thus differing from sarcoma of the body, in which there was little pain. Possibly in this variety of cancer the intra-muscular nerves were involved in the growth. The shooting,

darting, sickening pains associated with disease of the tubes was due to nothing but peritonitis. Hegar refers to cicatricial nodules in the broad ligaments, and even in the case of ovarian neuralgia it seemed probable that the pain was due to pressure upon the nerve before it entered the organ rather than to changes within it. Otherwise this pain would not be relieved by the relief of perimetrial adhesion, as frequently occurred.

The inference was to give a guarded prognosis in regard to the relief of pelvic pain. If the pain, associated with a fissured cervix, was due to cicatricial nodules in the broad ligament, we might cure the laceration and the endometritis, and yet the pain would continue. To remove the ovaries for the relief of pain was even more hazardous.

The speaker thought that gynecologists exaggerated the frequency of reflex pain. With Dr. Dana, he considered anæmia the most frequent cause of vertex headache. Pelvic reflexes were found in the upper lumbar and intercostal nerves. He had not found sciatica of ovarian origin, according to Dr. Mundé's suggestion. It might occur as the result of some exudates, but must be rare as a reflex pain. Dr. Mundé himself somewhat oddly remarks that this pain is relieved by a blister over the sciatic notch. Dr. Polk's plan of separating adhesions for the relief of pain presented scarcely less risk than the usual operations referred to. Treatment by electricity according to the methods of Apostoli gave the most satisfactory results. Reflex or transferred pains might also be due to inflammatory foci, and might be treated in the same way.

DR. GRAY, as a neurologist, felt at a loss to know how to discuss such a paper. Many pains besides those of pelvic origin centred in the back, such as muscular pains and the pains of peripheral neuritis. He had himself often referred patients to competent gynecologists for examination, and had found nothing in the pelvis to account for pain over the sacral, lumbar, or coccygeal vertebrae. Yet, on the other hand, one could not deny the capricious vagaries which distinguish the truly reflex pelvic pain.

DR. PUTNAM JACOBI remarked that while specialism assisted investigation, it was a misfortune to the patient. She did not consider that the writer of the paper had proved his position. Pelvic pain might be more definitely mapped out. The uterus, the central organ of the pelvis, was supplied by the lumbar

plexus; and lesions of this organ were accompanied by pain in the track of the lumbar nerves. Two or three other definite points were known. Pain referred to the distribution of the femoro-cutaneous nerve was the most characteristic accompaniment, not of ovaritis, but of ovarian neuralgia. Again, pain in the end of the spine might be spinal, ovarian, or endometrial in origin. A retroverted uterus without peri-uterine lesion would cause aching in the sacral region, but no coccydynia. The speaker considered pain from pelvic exudation rare and somewhat hypothetical. Even chronic peritonitis gave only a dull, aching pain which was quite tolerable except when the patient was moving about. The worst case which she had ever seen, one which finally died from an exacerbation, was comfortable when in bed. The ganglion had been found frequently diseased in cases of pelvic pain, especially in those associated with posterior perimetritis, and in some cases of violent hysteria, it had been found atrophied. This ganglion, situated between the body and the cervix, was often the site of excessive tenderness, and a permanent neuralgia might result from a perimetritis which would persist long after the removal of its cause.

DR. RANNEY quoted Dr. Beard as having said that the nervous system is like a mountainous region, in which echoes are returned with equal intensity from distant parts. This description was peculiarly applicable to pelvic pain. As a general practitioner he had frequently treated pelvic pain locally, without relief, in cases where it had finally disappeared upon the removal of a distant cause. It was not, in his opinion, possible to establish the seat of any pain unless removal of the supposed cause had established cure. He had failed to find compliance with this formula in the interesting paper under discussion.

DR. DANA stated that he had been disappointed often when sending patients with pelvic pain to gynecologists for examination; and that painful neuroses, even, had in some cases resulted from gynecological treatment.

DR. PECKHAM considered that the reader of the paper had underrated the suffering from direct pressure as a factor of pelvic pain. A retroflexed body or the hypertrophied cervix of an anteflexed body might cause a good deal of suffering by direct pressure upon the sacral nerves. Again, pain in the right or left iliac region might often be attributed to tension where, with a shortened broad ligament and lateral deviation of the uterus,

there was pulling upon the ligament of the opposite side. Pain persisting after operation might later be found to have disappeared. The eye which looks on the sun retains for a time its image. Thus the nerves of other parts after prolonged irritation retain the impression of that irritation and the habit of pain after the removal of the cause. Time is thus required in these cases to perfect a cure.

The speaker indorsed the value attributed to electricity by the author of the paper. Whether it acted by direct influence upon the nerves themselves or by modifying the pelvic circulation was not apparent.

DR. STARR read a preliminary report of the Stevens Commission.

The meeting adjourned.